Ideal Carehomes (Number One) Limited

Newfield Lodge

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Good**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

This inspection took place on 9 November 2015 and was unannounced.

Newfield Lodge is a modern, purpose-built care home, for 64 older people and is divided into four units two of which support people living with dementia. The home is close to Castleford town centre. The home has a nearby bus route, train station and some shops within close walking distance.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At the last inspection on June 2015 we asked the provider to make improvements in four of the five domains; Safe, Effective, Responsive and Well led. At the last inspection there were two breaches of the Health and Social Care Act (HCSA) 2008(Regulated Activities) (RA) Regulations 2014. At this inspection we saw improvements had been made. People who used the service told us they felt safe living at the home. Staff we spoke with had training in

Summary of findings

safeguarding and were aware of how to raise concerns. This meant people were protected from the risk of harm because staff had been trained to recognise signs of abuse.

Care plans used by the service identified people's support needs and any associated risk had an assessment and plan in place. This meant people received care that was centred on them as an individual and were protected from the risk of harm.

People who used the service felt there were enough staff to meet their needs. Staff we spoke with felt sometimes the service was short staffed but felt this did not impact upon the care of people within the home.

People received their medicines in a safe and timely manner. People we spoke with told us they received their medicine on time.

We saw aprons and gloves were in good supply and used appropriately by staff. This helped prevent the spread of infection. The home looked clean with no malodours.

Staff confirmed they received supervision and felt it was a useful way to receive feedback about their performance. Training for staff was up to date and staff felt the training helped them carry out their role effectively.

People had signed their consent for the use of their image and to share information with other professionals. Although has signed and agreed to their care record, they had not consented for the provision of personal care.

The service assessed people's capacity to make decisions in line with the relevant legislation and had made the appropriate applications for Deprivation of Liberty Safeguards.

People were offered a choice of meals and had regular drinks and snacks though the day. The service contacted the appropriate services if they had concerns about people's weight.

Care plans were reviewed monthly and updated to reflect the changing needs of the individual

People had access to outdoor spaces. People were supported to use the smoking shelter.

We saw staff spoke with people in a respectful manner. Staff told us they enjoyed working at the home. Staff interaction was warm and it was clear staff knew people very well.

The home had an open door policy and people could have visitors at any time of the day, except at meal times which was protected.

Staff spoke highly of the team they worked in and felt they worked well together.

Care records were person centred and focussed on the needs of the individual

The service organised activities which people participated in and enjoyed.

People we spoke with knew who they would talk to if they had any concerns.

People who used the service knew who the registered manager was. Staff we spoke with felt supported by the manager and they could approach them with any concerns.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had received training in safeguarding and were aware of their responsibilities in raising concerns. This showed people were protected against the risk of harm because staff were aware of their responsibilities.

In the previous inspection there were not always enough staff to support people. During this inspection we saw there were enough staff to meet people's needs.

Staff were able to administer medicines in a safe way. This showed people were protected from the risk of harm because medicines were safely administered by staff with skills and knowledge to do so.

Is the service effective?

Requires improvement

The service was not always effective

Staff received supervision to help them identify their training needs. This meant people were cared for or supported by suitably qualified, skilled staff.

The care records showed people had signed they had read and agreed to their care records but there was no signed consent for personal care.

Staff had training in the Mental Capacity Act 2005 and gave good examples of the need for consent and showed an understanding of the Deprivation of Liberty Safeguards. This meant people's human rights were protected by staff who had received the appropriate training.

People were supported to have a good diet and plenty of fluids. People had a choice of main course at mealtimes. This showed people had been supported to have enough to eat and drink sufficient amounts to meet their needs.

Is the service caring?

Good

The service was caring

We saw lots of warm interaction between people who used the service and the staff who supported them.

Staff had responded to people in a timely manner and people did not have to wait long periods of time to have their calls bell answered.

We saw staff knocked on people's rooms before they entered. Staff had a good understanding of the need to protect people's privacy.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not always responsive

Although care records centred on the needs of the individual they still contained gaps in information.

People were aware of how they could raise any concerns they may have

Activities were planned and people joined when they wanted to.

Is the service well-led?

Good 

The service was well led

The registered manager was aware of their responsibilities in maintaining an effective service.

The manager was visible throughout the home. People who used the service knew who the registered manager was.

Staff felt supported by the registered manager.

The registered manager carried out audits within the home to maintain people's safety.

Newfield Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 November 2015 and was unannounced. The team consisted of three adult social care inspectors, one specialist advisor in medicines and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection, we met with the local authority safeguarding team, the registered manager of the home and the operations director employed by Ideal Care Homes. The meeting had been arranged in response to concerns about the high number of notifications in relation to medicine errors received by the local safeguarding team and the Care Quality Commission (CQC).

We had also received a whistleblowing concern which alleged the service was not referring all medication errors to the CQC and the local safeguarding team.

Before an inspection we usually ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we did not ask for a PIR because the inspection had been brought forward in response to concerns that had been raised with the Care Quality Commission by the local safeguarding authority.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We looked at the health and safety audits which included, fire safety checks, medicine audits, water testing records and passenger lift checks. We reviewed the medication administration charts, three staff files and four care records. We spoke with the registered manager, a senior care worker and six care staff, twenty two people who used the service and one visitor.

Good

Is the service safe?

Our findings

At the last inspection we found there were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet the requirements of this part. At this inspection we found there had been an improvement in the allocation of staff within the home and a staff member was present in each unit.

People who used the service told us; “I'm not going to grumble, because I'm quite happy and comfortable. I think there is plenty of staff. They're always there if I need anything. I've got to know them and I've made good friends in here. I feel very safe,” And, “It's very comfortable”.

Another person told us, “I feel very safe here. You can lock your door from the inside, and they have the key to open it, but I don't do that. I don't like being behind locked doors, and I'm not worried about anything here. Obviously, you get low. You miss your friends and you can feel a little bit abandoned. Anyway – I've brought my own TV.” One person told us, “It’s alright here. I can be nasty, you know, but only when I need to be. But they're nice here, so I don't have to be.”

The home was divided into four units, two units classed as residential and two units for people living with dementia. The registered manager told us during the day they allocated two care staff and one senior to the unit for people living with dementia and two care staff and one senior to the residential unit. During the night they allocated one care staff to each unit with two staff ‘floating’ between the units. The registered manager told us staff were allocated to the units on a daily basis and it was the practice of the home to rotate staff around the units. The registered manager counted themselves amongst the staffing numbers and supported staff when required. They felt this number of staff was sufficient to meet the needs of people who used the service. During the inspection, we observed staff on each of the units at all times. Seven of the staff we spoke with felt there were enough staff to support people in a safe and timely manner. However one staff member felt that there were not always enough staff on duty but thought this did not impact on the care and support people received.

We looked at three staff files. The service carried out recruitment and selection in line with their policy. We saw potential candidates had completed a job application, had been interviewed by the registered manager and the service had requested two references prior to being confirmed into post. In two of the files we could not establish whether the service had carried out a Disclosure and Barring Service (DBS) check. We discussed this with the registered manager. They told us they had carried out a DBS check and would forward the necessary information to us which they did following the inspection. The DBS enables organisations make safer recruitment decisions by identifying potential candidates who may be unsuitable for certain work that involve adults. In another file we looked at there was a discrepancy in the application form where the staff member had not declared they had been suspended from their previous role. This had been investigated by the registered manager but there was no outcome of the investigation in the file. This meant the provider could not demonstrate they had taken all practicable steps to reduce the potential for people to be put at risk through unsafe recruitment practices.

Staff we spoke with told us they had received training in safeguarding and had a good understanding of what constituted abuse. They were aware of their responsibilities in reporting their concerns. The training information we had been given by the home confirmed staff had received training in safeguarding.

The care records showed care was planned and delivered in a way which ensured people’s safety and welfare. The risk assessments focussed on the individual and included; mobility, skin integrity and choking. The risk assessments had plans in place which directed staff on what steps they should take to reduce or eliminate the risk of harm. Some people demonstrated behaviour which could have a negative impact on others and one person who used the service told us, “Some of the residents can be argumentative but the staff try and smooth it down. There's always some people who don't get on. There's the odd one that stirs it up a bit, but the staff sort it out.”

The service had experienced a high level of altercations between people who used the service in the communal lounge and dining areas, this had been highlighted in the previous inspection. The registered manager had taken steps to reduce the number of altercations through training staff in managing challenging behaviour and staff having a

Good

Is the service safe?

presence in the lounge and dining areas. There had been a reduction in the number of notifications sent to the Care Quality Commission (CQC) relating to altercations between people who used the service.

We looked at the number of accidents and incidents recorded by the registered manager. During September 2015 38 falls had been recorded and the registered manager told us this was a high number which had raised concerns. The registered manager had analysed the records for the falls during September. They had identified most of the falls occurred during the night and the early hours of the morning when observations of people were not carried out as frequently as they should have been. The registered manager had increased the frequency of observations of people through the night and felt this led to a reduction in the number of falls. We saw the number of falls recorded during October 2015 had reduced to 11. This showed the registered manager had reviewed accidents and incidents to identify patterns or trends and had put in place plans to reduce or eliminate the risk of harm.

Prior to this inspection we had received concerns about the high number of medicine errors made by the service. The registered manager acknowledged there had been issues some of which involved the company providing their medicines and they were in the process of changing their supplier. They also felt the staff who administered the medication required further training and they would be putting this into action. We saw the training plan for November which included medication awareness training. There had been a reduction in the number of notifications sent to the CQC concerning medicine errors.

We observed the morning medicines round. The member of staff administering the medicines wore a tabard to indicate they were dispensing medication. This meant other staff were aware they were not to disturb them as they administered the medicines. We saw time was spent with each person to check that medication was taken. When the member of staff dispensed the medication to people in their own rooms, they ensured the medicine trolley was locked.

Some medicines must be stored in a refrigerator because storage at room temperature may cause them to be less effective. . The temperature of the medicines refrigerator should be monitored daily when it is in use and recorded. The fridge should have a minimum and maximum temperature which is usually between two to eight degrees Celsius. The service did record the temperature of the fridge but this was not being done on a consistent basis. For example, no checks had been carried out on the 3, 4, 6, 7 and 8 November 2015. For other months fridge temperature checks had been carried out daily. This meant the registered manager had put in place a system to reduce the risk of people receiving unsafe medicines but this had lapsed in the period prior to our visit.

Staff told us they had been trained to administer medicines and had their competency to do so checked on a regular basis. We looked at the competency checks carried out during 2015 which confirmed what staff had told us. This meant people were receiving their medicines from staff with the necessary skills and knowledge.

There was a plentiful supply of aprons and gloves for staff to wear and staff understood the need to keep people protected from the risk of infection. The home was clean throughout and we did not detect any malodours. The registered manager was aware of the need to prevent the spread of infection. They told us they were pleased with the recent score of 94% in their last infection control audit.

There were window restrictors on the windows. This reduced the risk of people falling out of the windows. We did not observe any trip hazards throughout the home and the bathrooms and toilets were free from clutter.

People had a personal emergency evacuation plan (PEEP) in place. A PEEP is a document which detailed the safety plan, e.g. evacuation route, equipment to be used and staff support, for a named individual in the event the premises have to be evacuated. This showed the service had taken steps to protect the people who used the service from harm.

Requires improvement

Is the service effective?

Our findings

We asked people who used the service whether staff had the knowledge and skills to support them. One person told us, “The staff are very good and they look after us well. I have really bad legs and they have to be bound. They do it lovely.”

However one person told us, “The young ones are alright. You can talk to them and they cheer you up, but some of the others think they're better than us, you know what I mean?” We asked what this person meant, but they did not wish to elaborate.

One of the relatives we spoke with told us, “Sometimes there could be more staff on and sometimes I think they could be better trained. You know, there's times – well, I don't expect them to jump to it, but well, anyway – you're probably best talking to her (relative) about these things.”

Staff had a period of induction prior to starting in their role. They told us they felt induction gave them the knowledge and confidence to carry out their role effectively. Staff told us they received supervision and the staff files we looked at confirmed this. Staff felt the supervision sessions were useful and a good way to gather feedback on their performance. We saw staff had annual appraisals which enabled them to identify areas for professional development.

In relation to training, staff felt the training at the home was, “very good and appropriate to give us the skills and knowledge to do our job.” The registered manager told us they had recently signed up with a company which offered e-learning. We asked them how they would assess the effectiveness of the learning on staff. They told us they had access to the e-learning accounts of staff to ensure modules had been completed and they would be carrying out observations of practice once staff had completed the e-learning module.

We spoke with the staff about their experience and understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguard (DoLS). The (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The staff we spoke with had a good understanding of the MCA and DoLS, for example they told us how important it was to gain consent from individuals before carrying out personal care. If people did not give their consent to personal care, staff told us they would respect people’s wishes but would try again and explain why it was important personal care was carried out.

We asked the registered manager whether relatives who had signed consent to care in people’s care records had in place a lasting power of attorney in health and well-being. A lasting power of attorney gives designated individuals the legal power to sign health care documents on behalf of people who are unable to make their own decisions in relation to their health and well-being. The registered manager confirmed relatives who had signed on behalf of others had a lasting power of attorney in place.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). In the care plans we looked at we saw where people were not able to make their own decisions a capacity assessment had been carried out. Two of the units had a coded keypad in place to prevent people leaving the home unsupervised, this meant people were being deprived of their liberty. However, the service had carried out capacity assessments and where people had been assessed as not having the capacity to make a decision to stay at the home; a DoLS application had been made. The registered manager told us they were in the process of training senior staff to make a DoLS application so that they had a better understanding of how DoLS fits in with their role.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met. We saw the service had applied for DoLS in relation to people who lacked capacity to make specific decisions such as staying in the care home.

We asked staff what they would do if the person refused personal care. One staff member told us, “I would ask myself is it me they don’t want? I would keep trying and explain why they need to get up. But sometimes people want to stay in bed and we will respect that choice.”

Requires improvement

Is the service effective?

Another staff member told us, "I would go back at a different time to see if the person is ready to get up when we go back, they are usually ready to get out of bed." This showed staff respected people's choice.

Care records were kept in a locked office which prevented unauthorised access to people's records. This meant confidentiality had been maintained.

We observed the lunchtime experience on all four units. We saw staff were discreet when they offered support to people to eat their meals. One of the staff members we spoke with told us they ate their meals with people so the lunchtime experience was normalised and it helped staff observe people who required support.

On the day of inspection we saw people had a choice between beef stew and dumplings or lambs liver and bacon for lunch. The main course was served with vegetables. There were alternatives for people who did not want the meat meal such as an omelette, salad or jacket potato with a choice of fillings. There was not choice of puddings; we only saw spotted dick and custard on offer. The hot food was served from a heated trolley. This ensured food was kept warm. The home did not heat plates up because of the risk of harm.

On one of the units we saw people had a choice of where they wanted to eat their meals. Some people ate at the dining table whilst others chose to eat in their rooms or in the lounge. The tables in the dining room were laid with table cloths and cutlery. People were offered a choice of drinks with their meals. We saw staff work together as a team during lunchtime, they made each other aware of what they were doing and this avoided confusion. However, we did witness an episode where a discussion took place between two staff members. One staff member said, "(name) doesn't like liver-so we will send stew and dumplings." Whilst this demonstrated the members of staff knew the likes and dislikes of the person they did not ask the person what they wanted as an alternative to liver.

Just after lunch one person said, "I enjoyed that. I wasn't outfaced today – sometimes they give you too much and it puts you off. You can always have more if you want." Some of the comments made by other people included; "The food could be better. It's alright and there's plenty of it. Sometimes by the time you get it, it's cooling off. It's because they put it on cold plates. The food itself is ok. There's choice and it's tasty – it's just the cold plate thing." And "We have fish and chips on a Friday which is very good – I mean really very good."

People's weight was monitored monthly or weekly depending on whether their weight was stable or they were losing weight. The GP or dietician would be contacted for advice if people were losing weight and supplements prescribed.

The menus on notice board in the dining rooms did not always correlate with the meal served. For example, the menu up on the day of inspection did not reflect the meal that was served. The service worked on a four week menu and the menu on the notice board was week one instead of week two. This might be confusing for some people who live with dementia and have difficulty with their ability to retain information. The notice board had a collection of photo cards of different food items but none of the photos were of the food on the menu. However, people seemed to enjoy their meal and the dining rooms were calm with music playing in the background.

In the care records we looked at we saw people had visits from other health professionals involved in their care such as General Practitioner's (GP's) and district nurses. Staff we spoke with felt the service was quick to involve other health professionals when there was a change in people's health and wellbeing. When people developed pressure ulcers, the service called in the tissue viability nurse to treat the ulcer and gave instructions for the staff to follow. If people developed chest infections, the service contacted the person's GP who would visit and prescribe the appropriate medication. One person we spoke with told us, "I'm not feeling very well. I've just had my flu jab and it's knocked me for six. They'll call my GP if I need anything. The other day I needed to go to the opticians in Pontefract. I went in a taxi with one of the girls."

The environment was not always conducive for people who live with dementia. Although there were photographs of people on the door to their rooms and there was signage on the doors to the bathrooms and toilets, the registered manager told us there were plans in place to improve the signage. They told us they felt the signs could be improved and we saw a letter from the head office of the provider asking the registered manager what type of signage they required.

Requires improvement

Is the service effective?

People had access to an enclosed garden. One person told us “The garden is lovely in the summer and I go out there when it’s warm.” Some people who used the service smoked and we saw people had access to a smoking shelter.

Good

Is the service caring?

Our findings

We asked people living in the home whether they felt staff were caring. One person we spoke with told us, “The other day I felt ill and I had to pull the cord in the bathroom. I'd got in a bit of a mess. They came straight away and sorted me out. They didn't make me feel embarrassed whatsoever. I can have a bath when I want. I just arrange it with one of the girls.” And, “The staff are alright. I've got to know them alright. It's hard, cos I can't see, so I don't see their faces, but I've got to know them now. They're very good, the girls. They've sorted me out talking books and tapes and everything.” Another person told us, “I have only been here a while but it is lovely and the staff are very good, I get on with them very well.”

Some people we spoke with were involved in their care record but other people told us their relatives were more involved.

We saw staff reacted quickly when people became distressed and agitated. During lunch, one person became agitated and shouting at other people at their table. A member of staff responded immediately, saying to the other staff “I'm going to sit with (name) for a while, alright?” They sat with the person and chatted about something else to distract them. We noticed this person liked looking at photos of their family and had a large collection of these in their room. After lunch, the member of staff said, “Come on, let's go and have a look at your pictures.” Later this person was shouting in their room. A member of staff went in to them and said “(name), how about you have a little rest now. You'll feel better after a nap. I tell you what, I'll bring you a cup of tea in a bit after you've had a rest. I'll pop a pillow behind you so you're a bit more comfy, how about that?” The person seemed to calm down after this.

One member of staff told us “(name) has got dementia, and most days are just a sweetheart, but they are having a bad day today. (Name) loves her family, and loves looking at pictures of them and showing them to people.” This showed staff had an understanding of people’s support needs and knew how to reduce people’s distress.

We heard staff calling people by their preferred name and people knew the first names for staff on duty. We asked staff about their experience of working at Newfield Lodge. They told us they really enjoyed working there. One staff member told us, “I love working here, there’s never a day when I don’t want to come to work.”

Staff told us they felt dignity and respect was an important aspect of their role. All the staff we spoke with had a good understanding of the need to treat people with respect and dignity. One staff member told us, “People are treated with respect” and “I always find time to sit down and engage with people.”

We observed staff had a kind and caring attitude toward people who used the service. We saw staff knocked on the door to people’s rooms and announce who they were before they entered. As one person was about to go out for a cigarette a member of staff stopped them and asked them to put a coat on as it was a cold day. The staff member then went to get a coat and the person went out for their cigarette. The visitors knew who the staff were and there was a lot of friendly banter between staff, people who used the service and visitors. One staff member supported a visitor to get their relative ready for a trip out as they could see the visitor was having difficulty encouraging their relative to get out of the chair and put on their coat.

We heard a number of conversations between people and staff members in people's rooms. These were all friendly and natural; when staff asked a question people were given time to consider their response. One person asked the member of staff if they could have some toast (the member of staff was just delivering morning coffee). They responded, “Of course. Do you want jam with it or just butter?” The member of staff returned a few minutes later with two slices of buttered toast.

Staff we spoke with told us they tried to encourage people to be as independent as possible and to use aids to support them mobilise. For example, one of the care records we looked at explained the process of re-building the person’s strength and mobility. This ensured the person would maintain their mobility and independence.

People who used the service had the option to use different rooms such as the quiet room to meet with their visitors, this ensured people had a place to meet with their relatives in private. Although visitors were welcome to the home at any time, meal times were a protected time for people and visitors did not visit at these times.

Good

Is the service caring?

The training plan we looked at showed staff were to receive training in end of life care. This would help staff understand the importance that people have the support they need to have a comfortable, dignified and pain free death. The registered manager told us they encouraged families to have an input into people's end of life care record. There were no people receiving end of life care at the time of inspection.

People were supported to have their religious needs met within the home. The registered manager told us people had a choice whether they attended any religious service and between five and six people had chosen to take Holy Communion.

Requires improvement

Is the service responsive?

Our findings

At the last inspection we found the care records had gaps and omissions which could lead to people's needs being missed or overlooked. Relatives and people who used the service felt there were not enough activities taking place in the home.

At this inspection, we found there had been some improvement in the recording of information in the care records and we also saw an improvement in the number of activities taking place within the home.

The registered manager told us they were about to introduce a new format for the care records which would enable staff to capture all the necessary information. The care records we looked at were not in the new format and we saw there were still omissions in the information being recorded.

We looked at four care records of people who used the service. They contained pre admission details, personal details, care assessments, risk assessments, daily records and multi-disciplinary meetings. One of the care records did not have a photograph of the person which would help new staff members identify people. People's needs were assessed and the resulting care records enabled staff to understand how people's needs could be met. Where there were specific conditions such as high blood pressure, the records contained guidance on how to recognise symptoms of high blood pressure and actions staff should take if they suspected deterioration in the person's condition. Although the records were person centred and contained details of people's preferences and their life history some of the care records had not been filled out consistently for example, not all the records had a life history for staff to understand people's life experience.

Staff we spoke with told us the care records were easy to read and understand and felt they were focussed on the needs of the individual. The care records were reviewed monthly and updated where necessary to reflect changes in people's condition. In one of the records we looked at the reviews were not always dated and in another record a review had not taken place. We discussed these omissions with the registered manager and they acknowledged the care records required updating and changing to become more person centred. They told us they had already started to implement the new care records but we had not looked at these records.

'Resident meetings' took place each month where a discussion to place about quality of food and planning activities. Each month the results of the meetings were displayed on notice boards around the home. They were divided into 'What we asked' 'What you said' and 'What we did'. We noticed people had asked for a bonfire party with fireworks. This event did not take place and the registered manager told this was due to the health and safety aspect of the fireworks.

The registered manager told us they had organised relatives meetings but these had not been well attended. They had changed their approach and tried 'relatives open surgeries' and again these had not been well attended, except in august when people's care plans were reviewed. Although relatives approached the manager to discuss any issues whilst they visited a relative in the home, the registered manager wanted to develop a more formal approach to relative involvement.

People were encouraged to take part in activities. We observed people dancing along to music played on the radio and during the morning on the unit for people living with dementia we saw one member of staff helping two people build bird boxes (a sort of 3D slot together 'jigsaw'). There were a couple of bird boxes already decorated and hanging outside in the courtyard garden.

After lunch, staff asked people if they wanted to watch a film. They asked what they would like to watch and people suggested 'The Sound of Music', the digital video disk (DVD) was played on the television in the lounge. Staff enabled people who wanted to watch the film sit where they could see the television. People discussed which songs they were going to sing along to and which were their favourite scenes.

People told use that they had regular visiting entertainers that are, "Very good." There is a "pub" (lounge room with a bar installed) in the downstairs residential unit, which has been recently used to celebrate a birthday. The provision of the bar had been requested by people during a previous survey. This showed the registered manager responded to people's requests.

Requires improvement

Is the service responsive?

The notice boards in the home advertised “In house voluntary jobs for residents”, which included: receptionist; maintenance; interview panel; hairdresser's assistant; meet and greet person; housekeeper; laundry assistant.

The registered manager told us at the moment, staff took the lead in arranging activities within the home. The home was in the process of recruiting an activities co-ordinator and the registered manager told us they hoped this would widen the frequency and type of activity available to people.

The home had recently held a memorial service for one of the residents who had passed away. The registered manager told us it was important for people to be able to attend funerals and services for their friends and acquaintances because they felt people needed to be able to express their grief and not forget their friends. Around the home we saw photographs of people who had lived in the home previously.

People were aware of the complaints system and people we spoke with told us they knew what to do if they any concerns. Complaints were recorded and responded to in line with the policy of the service. We saw complaints had been investigated and resolved to people’s satisfaction. Investigation into complaints was detailed and comprehensive.

Good

Is the service well-led?

Our findings

At the last inspection we found the systems in place to monitor and assess the quality of service provision was not always effective because no safety checks had been carried out in the absence of a maintenance person. The registered manager told us they had resolved the issue of poor quality assurance audits through the employment of a maintenance person. This was confirmed by the records of audits, including health and safety checks, we looked at during the inspection.

We spoke with the registered manager about their role and responsibilities. They told us they wanted staff to have a sense of ownership of the home and to work together as best they can. They felt staff were very good at their job and worked effectively as a team. We asked the registered manager whether they felt respected by the staff team, they told us, "Yes I do feel respected and staff will do as I ask them. I try harder with some staff because I need to ensure they get the support they need."

We spoke with the area manager, they told us they felt the registered manager worked very hard and had achieved a lot of positive change within the service.

The registered manager told us they enjoyed their job and felt they shared the values and vision of the service with the staff team. They felt committed to the continued improvement of the home.

The registered manager told us they felt confident in addressing poor practice. They said, "It's how you approach and speak to people." In one of the staff files we noticed poor practice was being addressed through supervision, appraisal and monitoring of staff performance. They worked with staff on 'the floor' providing support to people who lived there, which meant they had an in depth knowledge of people who lived there. Staff we spoke with felt supported by the manager. One staff member told us, "I feel supported by my manager. I can't fault (name)" another staff member told us, "I see the manager on the floor a lot, she is brilliant."

The registered manager carried out regular quality assurance audits in areas such as fire safety, water checks, mattress checks and mobility aid checks. This demonstrated the registered manager had effective quality assurance and governance systems in place to maintain a safe environment.

Staff meetings were held monthly and staff told us the meetings were a good place to discuss issues which needed to be addressed. They felt the manager listened to them and acted on their concerns. They felt involved in decisions made within the home such as activities planning. The service had in place a system called 'Your say'. Staff had to sign they had read about the incident. This showed us the registered manager encouraged staff to learn from incidents.

The registered manager felt staff had a good understanding of equality and diversity. They understood the need to treat people as individuals and respect people's choice.

The service used the 'residents meetings' to gather feedback on how the service was performing. We saw the registered manager used learning from the complaints they received to maintain a quality service.

The registered manager carried out spot checks on the administration of medicines and where any discrepancies had been noted they had been investigated and actions put in place to improve practice. The registered manager told us they felt having a presence on the units helped them monitor staff performance

In the care records we looked at we saw people had signed for the use of their photograph and for the service to share confidential information. People had signed their care record and when reviews had taken place people had signed to confirm they had been consulted. However, there was no record people had consented to personal care. We brought this to the attention of the registered manager and the operations manager. They told us there was a plan in place to change the way consent to personal care was recorded.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.